California Health Policy and Data Advisory Commission
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Minutes
CALIFORNIA HEALTH POLICY AND DATA ADVISORY COMMISSION
APRIL 17, 2006
Radisson Hotel
Sacramento, CA

The meeting of the California Health Policy and Data Advisory Commission was held at the Radisson Hotel, Sacramento, California. Chairman Vito Genna called the meeting to order at 10:00 a.m.

Present:	Absent:
Vito J. Genna, Chairperson	M. Bishop Bastien
Marjorie Fine, MD	William Brien, MD
Janet Greenfield, RN	Sol Lizerbram
Howard Harris, PhD	Corinne Sanchez, Esq.
Jerry Royer, MD, MBA	Kenneth M. Tiratira
William Weil, MD	

Staff Present: Kathleen Maestas, Acting Executive Director; Rebecca Markowich, Executive Assistant

OSHPD: David M. Carlisle, MD, PhD, Director; Joseph Parker, PhD, Health Quality and Analysis Division; Michael Rodrian, Deputy Director, Healthcare Information Division; Jonathan Teague, Manager, Healthcare Information Resource Center; Candace Diamond, Manager, Patient Discharge Data Section

Also in Attendance: Jeffrey Rubin, EMSA, Daryl Nixon, CAHF

Approval of Minutes: A motion to approve the minutes of the February 27, 2006 meeting was made, seconded, and carried.

Chairman's Report: Vito Genna, Chair

Chairman Genna announced that Commissioner Hugo Morris passed away recently. He said: "Mr. Morris often highlighted issues to make them transparent. He was an asset to the Commission and he will be missed." Mr. Morris' saying was, "With the collective minds that we have here, we should be able to conquer every healthcare issue in a bipartisan way." Chair Genna went on to read a letter from Hugo's son thanking them for their sympathy, in which he identified his father's contributions to bringing an understanding of economics to our youth.

A memorial service is scheduled for June 2, at 11:00 a.m., at 3888 Cherry Lane in Long Beach. This is near the Long Beach airport. Commissioners agreed to reschedule the June 9 meeting to June 2 so Commissioners can attend the memorial service. The CHPDAC meeting will begin at 1:00 p.m. at a hotel near the airport. Dr. Weil informed the group that Jet Blue airline flies directly from Sacramento into Long Beach.

A publication, National Nursing Home Scene, mentioned that there are 18,000 U.S. nursing homes throughout the country; 67 percent are for profit, 27 percent are nonprofit, and 6 percent are government. In California, there are 1,400 nursing homes, of which 14 percent are nonprofit. The average length of stay is 2.4 years. The average length of stay has been declining, but is skewed because of rehabilitation, mostly hip fractures and rehabilitation from strokes. The percentage of nursing home population aged 65 to 84 has declined, while the percentage of persons over 85 has increased dramatically. About 46 percent are 85 years and over, and that will continue to grow. Persons coming into nursing homes today have anywhere from five to eight different diagnoses, instead of just a couple. The acuity levels have gone up as well.

Health Data and Public Information Committee: Howard L. Harris, PhD, Chair

The last meeting of the HDPIC was well attended. The Committee will meet again on May 15. The agenda will contain both informational and action items. Dr. Harris encouraged Commissioners to attend the meeting.

OSHPD Director's Report: David Carlisle, MD, PhD, Director, OSHPD

Budget Hearing Process

OSHPD is in the middle of the budget hearing process. The Office has already been through phase one of the Senate Budget Committee and has been invited back to speak on phase two, addressing in more detail some of the proposed budget items. The discussions before the Committees focused primarily on the Seismic Safety and Hospital Plan Review Program. There are a number of changes being proposed in this area, subject to Governor's Office action requests from the Office.

The Office is working to develop some creative solutions that would greatly facilitate the plan review process. Staff is looking at techniques to bring modern earthquake science to bear on the stratification of hospitals and different seismic categories.

A recent newspaper article described the possible impact on the San Francisco Bay Area if there were another earthquake of the magnitude of the 1906 San Francisco earthquake. The article did not go into detail, but the assessment was probably based on a new method for disaster assessment, which has been applied elsewhere in the country. For instance, it forecast the devastation that New Orleans experienced as well as the most recent hurricane, and has been used to forecast hurricane effects throughout the nation. This type of science can be used to re-stratify hospitals in terms of their seismic risks.

When hospitals reported to the Office what their earthquake or seismic preparedness was, about 40 percent of hospital buildings and about 50 percent of hospital beds were the lowest performing seismic category that requires retrofit by 2008, or 2013 if they succeeded in applying for an extension with the Office.

Many hospitals basically did no engineering assessment. They basically acknowledged the buildings were bad and designated them the lowest category. This means that they would have to comply with the Act by 2008 or 2013. The first deadline is right around the corner. There is much policy concern about the status of hospitals, and the fact that many hospitals have not done anything to comply with the Act.

Because hospitals self-designated themselves, it may turn out that if a more modern understanding of seismic integrity of structures where hospitals are situated; many of those SBC-1buildings may actually not be SBC-1 buildings. OSHPD is trying to determine if there are methodologies that would allow that kind of assessment. There are SBC-1 buildings that are in relatively low seismic activity areas of California. Under current law, hospitals have to comply with 2008 and 2013 deadlines. Those buildings might be eligible for reconsideration, using modern science.

A question was asked if there are any teeth in the seismic safety program and the deadlines. Dr. Carlisle replied that the Office would report non-complying facilities to the Department of Health Services. The Department of Health Services' recourse would be to de-license the non-complying facilities.

There is a concern that many California hospitals are not taking sufficient steps to attain compliance by the deadline, with the consequence that they could face closure. The loss of significant number of facilities due to de-licensing a large number of hospitals, attention could affect access to care much as their loss in an earthquake. Actually pulling a hospital's license is a drastic step for California to take. There has been some talk of other intermediate remedies to encourage compliance, and there is active discussion going on.

Tenet has sold 19 of its hospitals and is moving from California rather than retrofit. The cost of compliance is a rapidly escalating target. As the deadlines for seismic safety compliance nears, there is a concentrated effort by contractors and designers. Competition for the existing supply of building materials such as concrete and steel from developing countries, such as India and China, is affecting the cost of every type of construction in California including hospitals.

Dr. Carlisle said that when he first became Director in 2000, the cost of building a hospital was estimated to be about a million dollars per patient bed. Recently, this cost has gone to two million dollars per bed, or more. Delays in plan reviews and construction schedules are a significant cost issue for hospitals.

Legislation Update

The Office is following several bills currently. A bill of interest is SB 1339 (Romero), which would ask the Office to create a working group to do primary data collection on the preparedness of the emergency and trauma systems in the State of California. This area historically, has been handled by the Emergency Medical Services Agency. It is unknown why the bill is being directed at OSHPD. In a discussion with Senate staff, one questions asked by the Office was, did they really think that the Office can do the job that EMSA can do in this area, especially with its new Director, Dr. Cesar Aristiguieta.

AB 2932 (Frommer) is a follow-on from the legislation of the past two years where the Office began following Charge Masters and reporting the cost for various hospital services.

This bill would make quality reports from the U.S. Department of Health and Human Services available and would inform the public further about hospital performance.

SB 167 (Speier) is a seismic safety bill, still in the Assembly Health Committee, where there has been no movement. It would address some of the seismic re-stratification strategies described above.

SB 602 is also in Assembly Health Committee, and has been there for some time. This bill would create the Department of Public Health, which would or would not include the Office, depending on amendments. Neither of these two latter bills has moved recently, but they are very relevant bills to the Office.

Office Update

On April 6, it was announced that the Office was a recipient of the Sacramento Workplace Excellence Leader Award from the Sacramento Area Human Resources Association, also sponsored by the Sacramento Bee. The Office was honored to even be nominated for this award. There have been some stellar winners in years past, such as Intel. Staff was quite surprised to actually win in the category of medium-sized governmental entity. The large governmental entity was SMUD, which also has a stellar reputation as a good workplace. It is quite an accomplishment for the Office and is a reflection of the investment that has been made in the managerial staff, with periodic managers and supervisors training, and the executive staff that has provided the type of leadership that the Office needs. The Office is undergoing a real change in becoming a positive work environment, and that environment is reflected in winning this award.

OSHPD has hired a new Chief Legal Counsel, Elizabeth Wied, who came from Child Support Services. Her arrival allows Beth Herse to return her full attention to the data and outcome activities, which was her assignment before she became Acting Chief Legal Counsel. To support Ms. Wied, Rebecca Markowich, who has been the Executive Assistant for CHPDAC for about one and one-half years, will be returning to the legal counsel office to be the Executive Assistant for that program. Thanks to Rebecca for her work in support of CHPDAC and the Committee for the Protection of Human Subjects.

Presentation on Emergency Medical Services Authority: Jeffrey Rubin, Chief of Disaster Medical Services, EMSA

EMSA is comprised of about 50 employees, with some of the most far-ranging responsibilities. Emergency medical services are provided out through 31 local EMS agencies. EMSA writes the regulations, sets the standards, provides monies to develop systems, and coordinates emergency medical services throughout California on a day-to-day basis.

EMSA licenses about 14,000 paramedics, and provides services and funds for emergency medical services for children. EMSA has set up a Poison Control Center system, and trauma center standards and systems throughout the State. EMSA has the responsibility for planning for and managing the State's medical response to disasters, with various partners.

California is obviously at risk. In terms of disaster, in modern history, California has had one or more of these events, such as floods, fires, earthquakes, and civil disturbance. Many of the disasters that have occurred in the last 16 or 17 years have impacted the medical and health system, each one with a little different twist.

Some of the other events, like the Oakland Hills fire, or the firestorms in Southern California, have created medical and health issues from the standpoint of large numbers of people being evacuated. People receiving healthcare services, either in a residential care facility, nursing home, or home health agency services, might suddenly need to be moved to a new place and need medical care services, pharmaceuticals, caregivers, etc. These have all been issues in the various disasters. During the floods of 1996-97, as an example, 162,000 people were evacuated from Sutter, Yuba, and Colusa Counties. That was the first major evacuation California had in years.

Most people think of civil unrest from the standpoint of law enforcement, but members of the community went to hospitals when there were no medical issues, they were just scared, and so they lived in the hospital for a few days.

The medical and health disaster system that EMSA put together is owned by no one, yet owned by everyone. Traditional public health services, environmental health services, mental health, outpatient services, etc., all have to come together with other partners. Partners that, on a daily basis, from a statutory, regulatory, business relationship standpoint, do not have much in common, yet in an emergency have to have a system to respond to the public's need.

There is a disaster medical and emergency management response system in California and, like any good system, it should have some principles to work off of; one of which is operational control by the locals. That means that an earthquake may be in a particular area, but everybody needs to be part of the problem and to help with the solution. Local officials remain in charge. It is EMSA’s job, and county and federal counterparts, to assist in that process.

EMSA is trying to bring medical and healthcare professionals together and put them into a team concept. The system is structured to facilitate mutual aid, meaning neighbor helping neighbor. EMSA is trying to set up a system like fire service and law enforcement where, at the time of a disaster, it is not completely foreign to ask a county in the north to assist a county in the south, in an organized way as part of the system. EMSA is trying to do resource typing and tracking, bringing common elements together -- train, equip them the same way, all in a common approach, with standardized communications.

EMSA’s role, at the State level is resource assistance, whether it is technical assistance or whether it is more physicians, planes for evacuation, more pharmaceuticals, and medical supplies. One cannot just plan for one kind of disaster because tomorrow or next week, there will be a need to plan for another type of disaster. An all-hazards approach is being looked at. The procedures, policies, and processes are in place. They are all available for an earthquake, a pandemic, whatever the event.

Since 9/11, the approach has been on weapons of mass destruction and terrorism. It is recognized that there is a significant law enforcement presence not seen in some other hazard responses but this needs to be merged into one seamless system.

Incident command came about in the 1970s when the fire service was sending 10 or 15 thousand fire fighters out to fight fires, and asking for the same resources, all using different terminology. A structured system was set up where, essentially, one person is in charge based upon statutory authority. Somebody does the planning and somebody else figures out where to get the needed resources (logistics). Somebody else figures out exactly what to do and carries out the operation, providing medical care, fighting the fire. Then somebody else keeps a record for reimbursement purposes.

Different government agencies have different authorities, based upon their statute, regulation, etc. There is an attempt to bring them together and recognize how to overlap them into a seamless response system.

The operational area structure says that all the political jurisdictions within the geographic boundaries of a county, the special districts, the cities, the county government, itself, and all form the operational area, and the operational area will speak with one voice when talking to the State. It begins to put together a chain of command so that everyone knows their role and knows how to move information and resource requests up and, at the State level, will fill that down through regions to the locals.

Starting with the lowest level, out in the field, the local government, there is only one emergency operation center at each level. At each of the levels, would be the different departments of State government. For example, at the operational area level, the county health department would have a department operations center. At the State level, EMSA has a department operations center, and joins with Health Services. OSHPD has a department operations center.

This position already exists in the statute. There is a regional disaster medical health coordinator, and a paid staff person provided to do the daily planning for mutual aid, and then to manage mutual aid during a disaster response.

There are all the State departments with authorities, such as Medical Response, Health Services, Public and Environmental Health, and some other partners. At the federal security level, there is Homeland Security and the Department of Health and

EMSA and DHS are two of the major players in medical and health planning and disaster response. EMSA is the State agency to promote preparedness and manage the medical response. A new role in the last few years is a move into operational response. EMSA is building an operational field capability to oversee and coordinate deployed medical and health units, and looking to increase the capability to provide field medical care through California medical assistance teams. The Governor has approved money to develop three medical assistance teams in California, and the management structure is being implemented.

Medical health professionals in a disaster area need to be fed, housed, and transported. They also need supplies. They are currently being supported by the Federal Government through their medical assistance teams.

Health Services is the statewide public health and environmental health leader. They have many different programs. On a daily basis, Health Services, with all their district and regional office staff are inspecting water systems, food-handling facilities, radiologic storage facilities, device storage facilities, licensing and certification, etc. They support EMSA in staffing a joint emergency operation center at the State level, and that supports the State operation center. Essentially, it is the medical and health branch for State operations.

One of the most important issues in a disaster is coordination of information. EMSA has been actively working on displaying information in a coordinated way and a real time way throughout the State, so people not directly affected by a disaster have an idea of what is going on and how they can assist.

OSHPD is a key partner when there is an earthquake. A hospital is viewed as either an asset or a liability in an earthquake. If it is an asset, local officials can continue to tell the public, over

the public information airways to send the injured to this site. If it is a liability, if there is no power, water, HVAC, or medical gases and there are many sick persons in that hospital, it is crucial that no more people go to that facility. The role of OSHPD is critical in figuring out the situation and getting that information to local officials, and to help make a decision as to liability or asset. OSHPD is a partner licensing and certification.

Social Services, has a tremendous responsibility at the State level, for care and shelter. Because of more hazards and higher population centers, California will probably have to evacuate in the future, and somebody has to receive and take care of them.

The Red Cross does not provide medical care, although the International Red Cross does. They will set up a general population center, but they do not know how to deal with the medically fragile, vulnerable, and disabled populations. These issues need to be looked at.

The National Guard formerly had a very robust medical presence, having one of the three medical brigades in the country. Much of that capability has been lost but they do provide a tremendous amount of logistic support. We have to rely more on our existing healthcare system.

Another key partner is Mental Health, whether it is the general populace or the responders. People may not be physically injured, but when they are traumatized, and everyone is in a disaster, it is critical to give them the support early on and maintain that support throughout the event and afterwards.

What is done during the first eight hours after a disaster makes some of the biggest difference. EMSA is building an ambulance “strike team" concept, where 125 ambulances and support vehicles can be moved rapidly throughout the State.

California Medical Assistance Teams (CMAT) are being created and trained. Hospitals and trauma centers have been given money for small caches for disaster response. A grant for the first year provided emergency and EMSA has been doing many different activities with hospitals.

A few years ago, EMSA funded an incident command system development for hospitals, called HECS, Hospital Emergency, and Command System. There is a national working group that includes the Joint Commission, American Hospital Association, FEMA, HHS, and Homeland Security. A draft curriculum has been completed. Work has begun on how to figure out simple ways to move information in a manner that is understandable, using common terminology, using common
systems.

There is a need to better develop plans to deal with the onslaught of patients. We need to recognize terrorism, weapons of mass destruction, and hold training exercises. OSHPD has been helpful with the Statewide Medical and Health Conferences. There is an annual statewide medical and health exercise, which began in 2000, with over 400 hospitals participating. There still are a couple of hundred hospitals participating each year. This year EMSA will be coordinating that with the Statewide Golden Guardian Terrorism exercise.

Most medical and healthcare providers are accustomed to a clean hospital or clinic environment and not working in a field situation. This may not be feasible when working in a field situation for several days; it is a different way of doing medical care.

In a pandemic, the Department of Health Services and the State's Public Health Officer will take the lead. DHS is finalizing a draft plan currently and looking for public input. They began with bioterrorism planning and how to deliver drugs to thousands of people.

Proposed Regulation Changes: Candace Diamond, Manager, Patient Discharge Data Section (Action Item)

At the last meeting, Commissioners reviewed the proposed changes to the regulations. Since that time, there have been changes in how the fees will be collected.

The regulations still contain disposition of patient codes and a proposal to close the report period at a particular time and not collect further reports. Facilities will be able to tell OSHPD that they have no data to report in a quarter or period. A reason for requesting an extension will no longer be necessary. The available extension time is 14 days. Some of the forms and the formats have been changed to coincide with the proposed regulation changes. Fees for freestanding ambulatory surgery centers will be an ongoing amount, as was suggested in law. The first law stated that OSHPD should obtain an estimate for the first year from hospitals and, thereafter the fees will be collected based on encounters. For this first year coming up, the estimate charges will be adjusted. The fees will be 50 cents per encounter.

A motion was made, seconded, and carried to approve the proposed regulation changes to the code.

As requested at the last meeting, a summary of penalties was prepared and distributed. There were few penalties for the two quarters in 2005 when the new program was implemented. Few facilities incurred penalties in more than one report period. It was thought that the educational process, reminders, bulletins, etc., prevented more facilities from incurring penalties.

Update on Healthcare Outcomes Center: Joseph Parker, PhD

The Healthcare Outcomes Center has two programs, the clinical data program, and administrative data program. Recently, managers were hired for both programs. For the last year and a half, the positions had been vacant. Dr. Holly Hoegh is managing the clinical data program that includes the heart bypass program, although Dr. Parker is still quite involved. Dr. Mary Tran is managing the administrative data program, often called CHOP, which includes acute myocardial infarction, pneumonia, and a few other studies. There are several contracts with universities.

A report was recently released on a mandatory program in California for reporting all CABG surgeries in licensed hospitals. Collection of data began in January of 2003. The first annual hospital report provides risk-adjusted mortality and quality ratings for hospitals. A report on surgeons will be released bi-annually. A clinical advisory panel advises OSHPD on the process of publishing these reports.

Three reports were previously issued as a result of the voluntary program, which is called the California CABG Mortality Reporting program, using 2000 through 2002 data. The report was recently released and received considerable media coverage. There were about 15 newspaper articles reporting on the release, most of which focused on local hospitals, especially if there was a better-than or worse-than-expected hospital.

There is a fair amount of anticipation of the surgeon level report, which is diligently being worked on right now. It is hoped that the report will be released at the end of 2006, which will

contain surgeon data for 2003 and 2004. The Clinical Advisory Panel will meet next week and needs to make some decisions before the report can be released. It is anticipated that it will be a lively, interesting discussion because the topic will be how to format and portray the surgeon results and a minimum number of cases required for public reporting. There are about 301 surgeons who will potentially be reported on in the next report.

The 2004 medical records audit is within a week or two of being completed. Forty hospitals, about a third of the hospitals in the State, were audited. Over 3,200 records were extracted.

Some new data elements have been added and regulations are now in force. With 2006 data, hospitals are asked to submit data about medical complications such as prolonged intubations, external wound infection that occurred within the hospital, stroke, renal insufficiency, and return surgery. These data elements are all from the National Society of Thoracic Surgeons, using their clinical definitions.

In addition, the Clinical Advisory Panel will be presented with some interesting information about use of the left internal mammary artery in isolated CABG surgeries. There are strong clinical indications, in most cases, for using that as a conduit in heart bypass surgery. There is evidence that patients receiving this graft, as opposed to vein grafts, have a longer life expectancy or less chance of another surgery.

It will be a challenge to release a report that combines an outcome measure and a process measure, which OSHPD has not done before. In terms of heart bypass surgery, this is one of the more important process measures. Decisions will be made on whether to include that in the report or, perhaps, issue a separate report.

Some other things that are being worked on are hospital abstractor training sessions to help coders learn how to code the new data elements. Training sessions in the north and south have been completed. There is no online reporting of these data, but will be in the future. A feasibility study has been completed. The volume of percutaneous coronary interventions, angioplasty, is rising. The volume of isolated CABG surgery is falling. OSHPD is reporting on one, but not reporting on the other.

The community-acquired pneumonia report was released a couple of years ago. It was the first report to include DNR as a risk factor and to use the condition-present-at-admission data element to distinguish co-morbidities from complications.

Most of the data linkages and most of the report tables have been completed for a second report. The report will use the same risk factor and the same report format. The report is scheduled to be released this summer.

Currently, we have filled two of the three vacant professional positions in the CHOP program, the administrative data program. This will represent a total replacement of the program staff.

Staff has been working on redeveloping a more updated AMI risk model. The technical report is being reviewed. It also recommends, as did the pneumonia report, that DNR and CPA fields be used in the risk model. This will be an agenda item at the next TAC meeting, hopefully, with a set of recommendations for review. A report might be out in late 2006.

The outcomes being used for the maternal outcomes report are unplanned maternal readmissions, expected readmissions, and perineal laceration. Hospitals will be identified on both of these measures individually.

The contracted report used 1999-2001 data. The contractor experienced some delays with this report. The contractor is working and meeting regularly with staff. A deadline has been established for later this summer to get this report back on track or proceed down another path. The data will be old and will need to be updated, using the most recent data, 2003-2005. It is anticipated that the report will be released in early 2007.

The same contractor is working on a validation study for this report. If the validation report is ready by summer, and staff can get up to speed, it is hoped that a 2003-05 report might be released in mid-2007. The validation study will involve data that is dated, and would probably need to look at updating that risk model.

The contractor was told that Commissioners and TAC members were not happy with the delay and the fact that he was publishing the data before he had completed his contract with OSHPD. The contractor has been asked to fulfill his contractual obligations and another deadline has been agreed to. The projects were under-budgeted, and this was not reported to OSHPD until later.

Recently the contractor has shown great willingness to spend time with OSHPD and meets regularly. He has obtained some additional resources from UCD. He often does much of the research work himself. In this case, he also had to tap some additional university resources. He still provides some consultation to OSHPD, generally unreimbursed, about projects in this area. It was an issue of not having adequate resources to complete the project.

The ICU outcomes study, once again a mortality study, was contracted with Dr. Adams Dudley of the University of California, San Francisco. He has submitted a final report, which is currently under OSHPD review. It will probably be released next month. A total of 32 hospitals contributed data. The individual hospital results are being masked because of the low participation rate. OSHPD would be potentially penalizing hospitals that voluntarily provided data. The report provides OSHPD with some alternatives on how to risk adjust for ICU outcomes, given political considerations. OSHPD probably will not go forward with this because there is no legislation to allow for collecting the additional clinical data needed for doing this report.

The results of the report will continue with the California Hospital Assessment Reporting Task Force, which is a voluntary initiative, to have more reporting of outcomes and process measures on California hospitals. They have borrowed some of the methods, the risk adjustment techniques that were piloted here, and they are now piloting an ICU measure for publicly reporting with this group.

There are over 220 of the largest hospitals that are on board this CHART initiative. It is a pilot measure, and approximately one hundred have committed to actually collecting the clinical data for doing the risk-adjusted ICU outcomes.

The simplest method for risk adjusting ICU data was suggested by CHART. It did not matter much which adjustment method was used, but the same conclusion was reached. One method included 86 elements, while the one selected only required the collection of 15 additional data elements. The data collection burden and the results from this study, which was shared with them, helped convince most hospitals that the collection of the15 data elements was the way to go. There was strong feedback from the hospitals and health plans.

Senate Bill 1973 provides OSHPD with the ability to expand the discharge data set, with some parameters for expansion. OSHPD contracted with Dr. Andrew Bindman of UCSF to write a report that recommends what OSHPD should be looking at when adding additional data elements. The final report has been accepted by OSHPD and is being prepared for publication. There are a couple of other reports in the pipeline, so it might take a month or two before it can be released.

OSHPD is just beginning some internal planning for engaging the hospitals in discussions about which of these data elements to pursue collecting. There needs to be discussions with hospitals to obtain feedback about the possibilities. Some feedback has been given in the context of the CHA Quality Committee that was very helpful. There needs to be more talk with the hospitals.

Following a meeting of the Health Data and Public Information Committee, CHIA representatives on that committee reported to their board, and a teleconference was held. It was a spirited discussion, with strong concerns over definitions and the need and purpose for each of the data elements that might be considered for adding. Reassurance was given that there will be more public discussion and that OSHPD has to determine which of the data elements have national standards. A commitment was made to them that OSHPD would do survey work and talk with the hospitals in a more global sense to determine what was already being collected and would work to meet some of their concerns. Every time a new element is added, it represents dollars for personnel, equipment, and programs that hospitals have to implement.

Commissioner Harris requested that this be an agenda item for the next HDPIC meeting.

Dr. Parker said there needs to be flexibility around the data elements that have been identified. Just because a report comes out does not mean that OSHPD will aggressively move forward and say this is what we absolutely have to have. This is a recommendation to OSHPD.

Another report that has been distributed is the Preventable Hospitalizations in California Report. It did not get much press attention. OSHPD used some prevention quality indicators from the Agency for Healthcare Research and Quality. These are hospital admission rates for ambulatory care sensitive conditions, for which evidence suggests could have been avoided through better outpatient care, including access to care.

There are other reasons why people might not seek medical care rather than not having good access to care. OSHPD used the PQI's, and the rates, which are age and sex adjusted population base measures, of admission per 100,000 population. Both census data and patient discharge data were used. The value is comparing counties to other counties, and using the State as a benchmark. Since the report came out, more research has been done to understand some of the trends that were seen in California versus the United States.

One highlight in the report is that there was a substantial drop in some of the admissions for some pediatric conditions. Pediatric Gastroenteritis and pediatric asthma declined from 1997 to 2003 from 23 percent and 18 percent respectively, and then we tracked that to the nation as a whole, using the Agency for Healthcare Research and Quality's national data. California saw a much deeper decrease in the pediatric gastroenteritis cases in that period, than the nation did from 2000 through 2003. There was a 17percent decrease in the nation, and 29 percent in California.

In the case of pediatric asthma, the admission rates went down 12 percent, as opposed to a national increase of eight percent for the same period. The various programs that are intended to extend health coverage to more children are perhaps working.

In diabetes-related conditions, there was not much difference in terms of California's admission rates and those of the nation, a 7.2 percent increase in prevalence, compared to 6.8 percent for the nation.

Admissions rates for other indicators were about the same, whether looking at the nation or California, in terms of increases in admission. Question was asked if they were divided into HMO or managed care. The answer was no, but Dr. Andrew Bindman has done some studies in that area. Managed care will give every diabetic a glucometer, and has a program to put him or her in a disease management program. When asked if this affected the admission rate, it was stated that Dr. Bindman has done some studies within Medicaid, looking at managed versus non-managed care counties, and found evidence to support this clinical intuition. OSHPD has not done an analysis with these data, which is a complicated analysis. OSHPD data do not tell what the denominator is for the HMO population. If an HMO member is admitted to a hospital, it is reported to OSHPD, but it is unknown who the members are prior to hospital admission. This report was submitted in advance of the public release to the local health officials for preliminary review by the counties.

A request was made to provide Commissioners with a copy of the slide presentation.

There has been some work on a gastric bypass surgery report. The programmer who has done most of the work on this project is no longer with OSHPD. The Office is committed to getting this report out, though. Staff was interested in exploring, in a descriptive way, mortality for the procedure, length of stay, charges, complications, and readmissions. There is a strong relationship between sex and mortality. Males are more than three times likely to die after the surgery. Staff would like to explore whether it is because men arrive sicker. That has been the generally accepted answer. There are risk-adjustment tools that need to be looked at. It is expected to see a trend in the surgery, in that younger people are opting for the surgery.

There has been a move recently to the lap band procedure; it is non-surgical, being used in Europe, but not so much in the United States. HMOs will not pay for the lap band. Now that ambulatory surgery data are reported, this report could become very interesting. That is another place to potentially take this report, and it will take longer to look at some of the differences in hospital outcomes, because there are 71 hospitals with a volume over 30. The mortality range goes from zero to 1.2 percent for hospitals that had more than 30 cases. There is a wide range in terms of the length of stay.

New Jersey, in late 2005, released a report on the outcomes there, which was quite comprehensive and well done. It could serve as a way to report at the hospital level. Raw mortality rates were provided. They did not go into risk-adjusted mortality.

In 2004, codes for lap banding were not available or were not consistently used. With 2005 data, one can distinguish between laparoscopic and non-laparoscopic cases. It is another reason to wait on this report to try to understand the data.

Healthcare Information Resource Center: Jonathan Teague, Manager

HIRC has worked with information technology staff to develop a way to present information on the web, a canned application that would allow more user interactive presentation of information and prepare graphs based on the data presented.

Mr. Teague then gave a presentation using some AHRQ inpatient quality indicators. The idea is just to get the information out there. It was a neutral descriptive statistical presentation.

Next Meeting:

At the next meeting on June 2, there will be a presentation on presumed consent for organ donors. In European countries that have presumed consent, if a person is killed and the organs are vital, they can be harvested unless a document is signed preventing this. These countries do not have to recruit donors.

Adjournment:

The meeting adjourned at 1:28 p.m.